

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2011
NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 REX GROSSMAN BLVD BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 30405 Facility Number: 006102</p> <p>Type of Survey: State Licensure Off Site AAAHC Accreditation Survey</p> <p>Date of AAAHC On Site Survey - ASC full survey December 13-14, 2010</p> <p>Date of ISDH off site review - February 9, 2012</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the November 28 - 29, 2011 AAAHC Accreditation Survey Report, it has been determined that Southern Indiana Surgery Center meets the requirements for ASC Licensure in Indiana.</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

GP2611

If continuation sheet 1 of 1